Washington State Department of Social & Health Services

MENTAL HEALTH DIVISION (MHD)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PO BOX 45320
OLYMPIA WA 98504-4320

DATE REVIEW COMPLETED

PROVIDER'S NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

WAC SUBSECTION	DESCRIPTION OF DEFICIENCY	PLAN OF CORRECTIVE ACTION	COMPLETION TARGET DATE	ACTUAL COMPLETION DATE

CERTIFICATION UNIT SIGNATURE DATE ☐ APPROVED ☐ DISAPPROVED	**I certify that I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated.**
MENTAL HEALTH DIVISION SIGNATURE DATE ☐ APPROVED ☐ DISAPPROVED	SIGNATURE OF ADMINISTRATOR OR OTHER RESPONSIBLE PERSON LEGALLY AUTHORIZED TO SIGN FOR LICENSE DATE